DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/02/2008 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C		
	09G18B		B. WING			03/17/200B	
NAME OF P	ROVIDER OR SUPPLIEI	₹	3259	T ADDRESS, CITY, STATE, ZIP COD 9 '0' ST, SE SHINGTON, DC 20020			
(X4) ID PREFIX TAG	TEACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 000	INITIAL COMME	INTS	W 000			4/10/08	
W 104	On March 13, 2008 at approximately 10:10 AM this office received a complaint via telephone from neighbors in the community. The neighbors alleged that bulk trash was observed for approximately two weeks on the curb-side.  An onsite visit was initiated on March 17, 2008. The findings of the investigation were based on observations at the group home, interviews with complaints, the staff at the group home, as well as a review of records.  Although the investigation failed to substantiate any violation of the law of federal regulations to support the allegations. Incidental findings revealed that the facility's Governing Body was not in compliance with federal regulations.  483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.		. W 104	W000 ILS HAS PUT A BULK TRASH PROTOCOL IN A PLACE TO ENSUR COMPLIANCE WI FEDERAL REGUL	TH		
	Based on recording failed to ensure Policy and Proceed to incident report or emergency procedure of the finding incidents of the finding incidents of the finding incidents of the facility of	RD is not met as evidenced by: d review, the Governing Body its Incident Management System redures were followed with regard riting services of law enforcement bersonnel by a staff for one of the re facility. (Client #1)  ludes:  lent reports on March 17, 2008 at 11:30 AM revealed that Client #1 without permission and walked t. Staff followed the client while			2008 APR 11 P 1: 45	BERARTHENT OF HEALTH HEALTH REGULATION ADMINISTRATION	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
09G188  NAME OF PROVIDER OR SUPPLIER				B. WING 03/17/2008 STREET ADDRESS, CITY, STATE, ZIP CODE			
INNOVATIVE			3259 'O' ST, SE WASHINGTON, DC 20020				
(X4) ID PREFIX TAG	YEARL DEELCIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	I .	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ひひとひ ひだ ここし	(X5) COMPLETION DATE
W 104	another staff persit While the client with Police Patrol car with Police Officer her into the facility and cancelled the Review of the fact System Policy and to report all incide emergency person Health/Health Re (DOH/HRA). Revidence that DO incident.  Interview with the Professional on I acknowledged the Review With the Professional on I acknowledged the Revidence that DO incident.	on called non-emergency (311). as walking down the street, a was coming down the street. It spoke to the client and directed it. At that time the staff called 311 call.  Illity's "Incident Management of Procedures" required the staff cants of law enforcement or sinnel to Department of gulations Administration view of records failed to provide oh/HRA had been notified of the Qualified Mental Retardation March 19, 2007 at 2:00 PM at the DOH had not been notified ecause the client was not taken		104	W104 INSERVICE TRAINING ON INCIDENT REPORT WAS DONE. ILS WILL CONTINUE TO ENSUR THAT ALL INCIDENTS REQUIRING LAW ENFORCEMENT OR EMERGENCY PERSON ARE REPORTED TO DO	TING E	4/10/08

HRA

STATE FORM

PRINTED: 04/02/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) P		(X1) PROVIDER/SUPPLIE				C 03/17/2008			
325			3259 'O' S1	REET ADDRESS, CITY, STATE, ZIP CODE 159 'O' ST, SE ASHINGTON, DC 20020					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD SE	(X5) COMPLETE DATE		
000 ا	INITIAL COMMENTS			1 000	<del></del>		4/10/08		
	this office receive from neighbors in alleged that bulk the approximately two An onsite visit water The findings of the observations at the complaints, the state are view of received any violation of the support the allegate revealed that the not in compliance	estigation failed to sub le law of federal regu- ations. Incidental find facility's Governing E with federal regulati	phone neighbors or side. 7, 2008. cased on riews with e, as well estantiate lations to dings addy was	1370	1000 SEE W000				
1379	each GHMRP sh Health, Health Fa unusual incident interferes with a arrangement, we places the reside be made by telep followed up by w twenty-four (24)  This Statute is r Based on record failed to ensure Policy and Proce regards to incide	reporting requirement all notify the Department acilities Division of an or event which substresident is health, we all being or in any other at risk. Such notification with hours or the next work of the first as evidenced in review, the Governing its Incident Management reporting services emergency parsonne	nent of y other antially elfare, living er way cation shall nd shall be hin rk day.  by: hg Body nent System with of law	1379					
Health Reg	pulation Administration	OVIDER/SUPPLIER REPRE	ATT .	IGNATURE	EXECUTIVE DI	Ecros	(X5) DATE  4 //3 /c		

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		(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
09G188						03/17	/2008
NAME OF PROVIDER OR SUPPLIER STREET ADD					TATE, ZIP CODE		
INNOVATIVE 3259 'O' S WASHING				T, SE TON, DC 20	020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
I 379	Continued From pa	ige 1		1 379		'	4/10/08
	for one of the five residents in the facility. (Resident #1) The finding includes:				<u>W1379</u> SEE W104		
	(Resident #1)		Resident d walked dent while ncy (311). e street, a street, a and e the staff of the staff of provide fied of the ardation PM een				
			·	-			

S7(Q11